Today's date: _____

BLOSSOM

Welcome to Blossom Pediatric Dentistry and Orthodontics

Patient name (include nickname you would like us to use) | Age | Birth date

Home address

( ) Home phone | ( ) Business phone | ( ) Cell phone

Gender (identity if different than birth)

E-mail address

Patient Social Security Number

Patient living with: Mother, Father, Spouse, Self, Other _____

Patient employer/school

Spouse's name/occupation (if applicable)

Parent/Guardian Name

Relationship to patient

Preferred phone number

Preferred e-mail address

Address

Date of Birth | Social Security Number

Place of employment

Parent/Guardian Name

Relationship to patient

Preferred phone number

Preferred e-mail address

Address

Date of Birth | Social Security Number

Place of employment

Individual financially responsible for this account _____

Address/phone number if different than above _____

Is patient covered by insurance for orthodontic treatment? ☐ YES ☐ NO

Medical History (has the patient ever had or currently have any of the following)

- ☐ Heart conditions
- ☐ HIV / AIDS
- ☐ Allergies
- ☐ Anemia/bleeding disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ High or low blood pressure
- ☐ Cold sores
- ☐ Diabetes
- ☐ Endocrine problems
- ☐ Emotional problems
- ☐ Epilepsy/seizures
- ☐ Hearing problems
- ☐ Ear/nose/throat condition
- ☐ Head/face injury
- ☐ Hepatitis
- ☐ Herpes
- ☐ Kidney problems
- ☐ Lung disease
- ☐ Eating disorders
- ☐ Oral ulcers
- ☐ Previous Surgery
- ☐ Rheumatic fever
- ☐ Thyroid problems
- ☐ Birth defects
- ☐ Cancer/tumors/radiation treatment
- ☐ Stomach ulcers/hyperacidity

Comments

Has the patient been under the care of a physician during the past two years other than routine physical? ☐ YES ☐ NO

If yes please explain _____

Does the patient require antibiotic premedication for dental procedures for any reason? ☐ YES ☐ NO

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Current Medications (reason for taking them) _____
Has the patient reached puberty? (menstruation, hair) ☐ YES ☐ NO (this information is used to assess growth)

Does the patient have allergy to:

☐ *Nickel* ☐ *Seasonal grass* ☐ *Food* ☐ *Latex* ☐ *Ibuprofen (Advil)* ☐ *Acetaminophen (Tylenol)* ☐ *Acrylic* ☐ *Drugs* ☐ *Other* _____

Respiratory Information

Does the patient breathe through their mouth?

☐ *Seldom* ☐ *Sometimes* ☐ *Usually*

☐ YES ☐ NO Snore when sleeping?
☐ YES ☐ NO Have frequent colds?
☐ YES ☐ NO Have frequent stuffy nose?
☐ YES ☐ NO Have frequent sore throat or tonsillitis?
☐ YES ☐ NO Have chewing or swallowing difficulty?
☐ YES ☐ NO Has the patient ever received treatment from an allergist or ear, nose, and throat specialist?

Dental and Temporomandibular Joint History

☐ YES ☐ NO Has the patient ever had any unusual dental experiences? **Specify if yes** _____
☐ YES ☐ NO Were the patient's teeth cleaned at his or her last dental checkup? **Date of last dental checkup** _____
☐ YES ☐ NO Has the patient ever been treated for TMJ problems?

Has the patient ever had or currently have any of the following:

☐ Difficulty opening their mouth
☐ Clicking in the jaw joint
☐ Pain on chewing/yawning/opening wide
☐ A bite that feels uncomfortable
☐ Jaw that locks, gets stuck
☐ Noises in or from the jaw joint
☐ Grinding or clenching of teeth
☐ Thumb/finger/lip sucking habit
If discontinued at what age? _____
☐ Tongue thrust or other functional problems
☐ Chipped or injured teeth (baby or permanent)
☐ Teeth that are sensitive to hot/cold
☐ Jaw fractures, cysts, mouth infections
☐ Bleeding gums, bad taste/odor from mouth
☐ Periodontal/gum problems
☐ Speech problems
☐ Loose fillings

How often does the patient brush or floss? _____ Has the patient had previous orthodontic consultations? ☐ YES ☐ NO
Previous orthodontic treatment: *Date* _____ *By Dr.* _____
Why is the patient/parent seeking this consultation? _____
What is the primary problem? _____
What is expected from orthodontic treatment? _____
Additional comments/concerns _____

Signature of person completing this form _____ Relationship to the patient _____
Date _____

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Dental Insurance Information:

Parent/Guardian Name

Relationship to patient

Social Security Number

Date of Birth

Employed by

Business Address

Business Phone

Insurance Co.

Group #

Address

Phone

Parent/Guardian Name

Relationship to patient

Social Security Number

Date of Birth

Employed by

Business Address

Business Phone

Insurance Co.

Group #

Address

Phone

Parent/Guardian Name

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Social Security Number

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